Application for Medical/Osteopathic Licensure
Kentucky Board of Medical Licensure

310 Whittington Parkway
Louisville, Kentucky 40222
(502) 429-7150, Ext. 222 Calls Taken 8:00am – 12:30pm, ET

All applicants for licensure in Kentucky are required to submit their background credentials to the Federation Credentials Verification Service (FCVS), unless you currently hold an Institutional Practice Limited License or a Residency Training License in Kentucky - in either of those cases, you will be required to have USMLE Step 3 scores sent directly to the Board (if you have not already done so) and you will need to have your post-graduate training program verified by your Program Director on Form #4. FCVS is a service of the Federation of State Medical Boards and was created to help simplify the licensure process for physicians, both MD's and DO's. FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information when applying to other state medical boards. (Most states accept FCVS, but you may want to check with each state that you wish to apply for medical licensure.) **The FCVS application AND the Kentucky Board of Medical Licensure application are to be completed simultaneously but independently**. Notification of any materials needed by either organization to complete the application, will be forwarded separately to you by the FCVS or the Kentucky Board of Medical Licensure.

FCVS Application Process

The primary source credentials of core documentation are verified in one uniform process created by FCVS and used in a lifetime portfolio for the applicant. **By using this service, the following core credentials are verified and kept in your lifetime portfolio for future credentialing by the FCVS:**

Identity
Medical Education Verification
Postgraduate Training Verification
Exam Scores
ECFMG and/or Fifth Pathway

You should **first** complete the FCVS application form and forward that directly to the FCVS along with their required fees. You should expect the FCVS verification process to take a minimum of 8 weeks if this is your initial application with the FCVS. The address, telephone number and website are:

Federation Credentials Verification Service
PO Box 970900
Dallas, TX 75397-0900
(888) 275-3287
www.fsmb.org

The FCVS will provide all support of their credentialing process. Do Not contact the Kentucky Board of Medical Licensure regarding the FCVS application. The FCVS has a dedicated staff to ensure the processing of your application in a professional and timely manner. The FCVS will provide an acknowledgment of receipt of your application in approximately **three days**, a subsequent notice of items needed to complete the credentials verification process in approximately **ten days**, and periodic reminders about any materials that remain outstanding every **three weeks** thereafter. In addition, each applicant will be given a unique PIN number that will allow you to check the status of your application on-line. If you have previously completed the application process through FCVS, you will need to request a subsequent application packet.

Upon completion of all information and a final review for accuracy, the FCVS will forward your "Physician Information Profile" containing certified photocopies of your credentials directly to the Kentucky Board of Medical Licensure.

Kentucky Board of Medical Licensure Application Process

Next, you will need to complete the application for the Kentucky Board of Medical Licensure (KBML) and submit this application directly to the Board along with the $250.00 fee. You may submit your KBML application to the Board at the same time that you submit your FCVS application to the Federation of State Medical Boards. KBML will use this information, along with the FCVS Profile, to assess your qualifications for licensure.

Additionally, the Board has incorporated the Common License Application - Form (CLA-F) into its application. This form will make it easier for physicians to apply for licensure in states that utilize this form. Kentucky is one of the first states to utilize the CLA-F, so please contact the other boards to which you want to apply to find out if they have incorporated the CLA-F into their state applications.

Applications will be reviewed in the order they are received in our office. It takes approximately 60 – 90 days to complete the processing of an application, assuming you have submitted all necessary forms and all outside information/verifications have come in to the Board, including the FCVS Profile. If you have malpractice, disciplinary history, or we receive any negative or derogatory information during the processing of your application, ***you will need to allow an additional 30 – 60 days to complete***. **The Board does not accelerate processing of one applicant at the expense of another because of a premature commitment made on your behalf, nor will it forego any elements of its screening process. Please do not make firm commitments to start work on any certain date until you have your license in hand.**

Once your application has been reviewed, you will receive an acknowledgement letter advising you of anything still needed to complete your file. You should allow at least 30 days for this process. Please do not contact the Board for the status of your application until such time. ***Only the applicant and the person authorized by the applicant will be able to obtain information regarding your file***.

Applications must be printed legibly or they will be returned. Please complete all questions in its entirety. Do not leave any blanks or time not accounted for. Mark N/A in areas not applicable. Incomplete applications will remain in our office for one (1) year from the date your application is stamped received in our office. After one year, your file will be purged and you will have to start the application process over in its entirety including the fee. Also note that the **$250.00 licensure fee is non-refundable** so be sure that you meet **all requirements** for licensure, which are listed on the following page, before completing and returning the application to this office.

We ask your cooperation in limiting your calls to the office to check on the status of your application. Please allow at least 30 days to receive notification of receipt and status (this could be delayed during peak months). When we use our limited staff resources on the phone, we are forced to delay processing of applications. All information regarding the status of a file will be in writing or may be obtained by calling (502) 429-7150 Ext. 222 between 8:00 a.m. and 12:30 p.m., ET, Monday through Friday. ***Please note that calls will only be taken during this timeframe from the applicant and persons authorized by the applicant.***

Requirements for Medical/Osteopathic Licensure in Kentucky by Endorsement

1. All applicants' must be a graduate from a medical school approved by the Board. All medical schools located in the United States and Canada approved by the Liaison Committee on Medical Education (LCME) or the Canadian Medical Association are approved by the Board. Medical education obtained outside the United States or Canada is evaluated by the Board on an individual basis and must be listed in the World Health Organization directory of medical schools or in the International Medical Education Directory (IMED) maintained by the Foundation for Advancement of International Medical Education and Research (FAIMER).

2. All applicants must complete a minimum of **two (2) years post-graduate residency training** approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA). Canadian training programs accredited by the National Joint Committee for Approval of Pre-Registration Physicians Training Program, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians are considered equivalent to graduate medical education in an approved training program in the U.S.

3. All applicants must have passed an approved licensing examination in which all parts, components and/or steps have been completed within a **seven (7) year time frame** from the passing of the first Step, Part or Component. The following examinations are acceptable:
    - **USMLE** Steps 1, 2, 3
    - **NBME** Parts 1, 2, 3
    - **NBOME** Parts 1, 2, 3
    - **FLEX Component 1 and Component 2**(75 or above on each component)
    - **FLEX** taken in one sitting with a FLEX weighted average of 75 or above
    - **State Board Exam** if taken prior to 1972 with overall average of 75 or above in one sitting
    - **COMLEX**
    - **LMCC**

4. International medical graduates ***must*** possess permanent ECFMG certification or proof of being a diplomat of an approved American specialty board.

5. All applicants must be able to understandably speak, read, and write the English language.

If you meet these requirements, please complete the enclosed Application packet for Medical/Osteopathic Licensure. **If you do not meet all of these requirements, YOU SHOULD NOT CONTINUE** with this application packet, as the **fee is nonrefundable**.

Kentucky Board of Medical/Osteopathic Application Instructions
Faxes Will Not Be Accepted

1. **Complete the Federation Credentials Verification Service (FCVS)** application. In order to obtain the FCVS application, go to **www.fsmb.org** and click on "Credentialing/Data Services," then "FCVS Homepage".

2. **Complete the Kentucky Application for Regular Licensure by following the instructions for "Using FCVS".** The application consists of two parts: the "Application for Physician Licensure" (Common License Application Form) and the "Kentucky Addendum to Application". You must provide a response to each section of the application as instructed. Mark "N/A" if not applicable. Submit this application to the Kentucky Board of Medical Licensure **along with the non-refundable $250.00 Fee** by either check or money order.

3. **Complete the top portion of the Licensure Verification Form (Form #1)** and forward it to each state and/or Canadian Province in which you hold or have ever held a license to practice medicine or osteopathic medicine. This includes Temporary licenses and/or training or education permits, whether the license is current or not.

4. **Complete the Kentucky Addendums 1 and 2**.

5. **Complete the Kentucky Addendum 3** if you will need to apply for a Temporary Permit. **(Refer to the Temporary Permit Form for information.)**

6. **Complete the Kentucky Addendum 4 and 4A**. This form should be completed by all hospitals/clinics, locum tenens assignments, and/or moonlighting within the past 5 years. ***Include all places that you have practiced medicine in the past 5 years, excluding private practice***. Form 4A should be completed by administration or chairpersons and submitted directly to the Board.

7. **Complete the Kentucky Addendum 5**. Two physicians who are familiar with your medical practice must complete the reference forms. If you are a resident applying for your first license, the Program Director and a senior attending physician who is familiar with your medical practice should complete these forms.

8. **Kentucky Addendum 6**. All applicants for medical/osteopathic licensure must comply with the 2-hour HIV/AIDS education requirement mandated by the Kentucky General Assembly. A list of approved courses may be obtained by going to **http://chfs.ky.gov/dph/training**. A course is only approved if it is listed on this website. The Addendum 6 Affidavit of Reasonable Cause may be signed and submitted with your application in order to meet a deadline. However, the completed approved course certificate must be submitted before a full and unrestricted license will be issued.

9. **Complete Kentucky Addendum 7**. List all Category 1 CME credits you have obtained within the past three (3) years. **Do Not send documentation**.

10. **Kentucky Addendum 8**. Effective August 15, 2003, all persons applying for a Kentucky medical/osteopathic license must submit an FBI Criminal Background Check according to KRS 311.565. Addendum 8 explains in detail how to obtain and submit this information to the Board. ***No applicant shall be issued a medical/osteopathic license until this background check has been received and cleared.***

11. **AMA/AOA Physician Profile**. ***All applicants must complete an AMA or AOA Physician Profile***. This profile must be ordered directly from the AMA or the AOA websites and must be completed by both members and non-members:
https://profiles.ama-assn.org/amaprofiles or **www.aoa-net.org/ProductsServices/services.htm**

You must complete this profile on-line. The AMA/AOA will forward your profile request directly to the Kentucky Board of Medical Licensure. If you need additional information, please contact AMA toll-free at (800) 665-2882 or AOA at (312) 202-8000 or toll-free at (800) 621-1773.

12. **National Practitioner Data Bank Request**. ***This must be completed by all applicants*** on their web site at: **www.npdb-hipdb.com** This data bank collects information from all state medical boards and healthcare facilities. Complete the Self-Query report form on-line and mail it directly to the NPDB for processing. The reports will be mailed directly back to you. When you receive the Self-Query Report, forward ***both*** originals to the Kentucky Board. One report will be completed by the NPDB and one report by the HIPDB.

All applicants must have the final approval by the Board before a medical/osteopathic license is issued. Applications completed by the deadline will be placed on the agenda for the next available Board meeting. Please refer to our website for Board meeting dates and deadlines. The Kentucky Board meets quarterly. If you qualify for a Temporary Permit, you may wish to complete the Temporary Permit form to begin working in Kentucky during the interim of the quarterly Board meetings. Refer to Addendum 3 for information on obtaining a Temporary Permit.

Application for Physician Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service and one when you are not using FCVS. Please use the checklist that applies to you.

	Not Using FCVS	Using FCVS
Completed Application	☐	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐	☐
Notarized copy of birth certificate or current, valid passport	☐	Not Applicable
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	☐	Not Applicable
Medical school transcripts sent to the Board by your medical school	☐	Not Applicable
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	☐	Not Applicable
Postgraduate Training Verification form sent to the Board from all programs you attended	☐	Not Applicable
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	☐	Not Applicable
Examination transcripts sent to the Board	☐	Not Applicable
ECFMG (if applicable) Status Report sent to the Board	☐	Not Applicable

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

M.D. ☐ D.O. ☐

_____

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone _____

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/ /

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

Gender | Social Security Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name

Address

City

State

ZIP Code

Country

Attendance Dates (From – To)

Graduation Date

Degree

2. School Name

Address

City

State

ZIP Code

Country

Attendance Dates (From – To)

Graduation Date

Degree

Applicant Name: Date:

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name _____

Address _____

City _____

State _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Completion Date _____

Degree (Fifth Pathway Certificate) _____

Institution name where rotations performed _____

Address _____

City _____

State _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Certification Date _____

Applicant Name: _____ Date: _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name _____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

2.Hospital Name _____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

Applicant Name: _____ Date: _____

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State	_____	☐ P ☐ F	_____
FLEX Pre-1985	_____	☐ P ☐ F	_____
FLEX Component 1	_____	☐ P ☐ F	_____
FLEX Component 2	_____	☐ P ☐ F	_____
LMCC – Single	_____	☐ P ☐ F	_____
LMCC – Part I	_____	☐ P ☐ F	_____
LMCC – Part II	_____	☐ P ☐ F	_____
NBME Part I	_____	☐ P ☐ F	_____
NBME Part II	_____	☐ P ☐ F	_____
NBME Part III	_____	☐ P ☐ F	_____
NBOME Part I	_____	☐ P ☐ F	_____
NBOME Part II	_____	☐ P ☐ F	_____
NBOME Part III	_____	☐ P ☐ F	_____
SPEX	_____	☐ P ☐ F	_____
COMVEX	_____	☐ P ☐ F	_____
COMLEX	_____	☐ P ☐ F	_____
USMLE Step I	_____	☐ P ☐ F	_____
USMLE Step II	_____	☐ P ☐ F	_____
USMLE Step III	_____	☐ P ☐ F	_____

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

Applicant Name: _____ Date: _____

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date, leaving no time period unaccounted for in your resume. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

3.

From:
Month: _____
Year: _____

To:
Month: _____
Year: _____

Practice/Employment Name _____
Practice/Employment Address _____
City _____
State _____
ZIP Code _____ Country _____
Position and Department _____ % Clinical _____ % Administrative _____
Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

4.

From:
Month: _____
Year: _____

To:
Month: _____
Year: _____

Practice/Employment Name _____
Practice/Employment Address _____
City _____
State _____
ZIP Code _____ Country _____
Position and Department _____ % Clinical _____ % Administrative _____
Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

5.

From:
Month: _____
Year: _____

To:
Month: _____
Year: _____

Practice/Employment Name _____
Practice/Employment Address _____
City _____
State _____
ZIP Code _____ Country _____
Position and Department _____ % Clinical _____ % Administrative _____
Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

6.

From:
Month: _____
Year: _____

To:
Month: _____
Year: _____

Practice/Employment Name _____
Practice/Employment Address _____
City _____
State _____
ZIP Code _____ Country _____
Position and Department _____ % Clinical _____ % Administrative _____
Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

Form #1

Licensure Verification Form
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: _____

Address: _____
Street City State ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date: _____

Is this license current? ☐ Yes ☐ No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

Board Authorized Signature: _____

Affix Board Seal Here

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Applicant Name: _____ Date: _____

Form #2

Malpractice Liability Claims Information

(Copy this form to report multiple claims)

Name of Patient Involved: _____

In which state did the action take place? _____ Which court? _____

Case number _____

Current status of this claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other _____

Amount of judgment or settlement $ _____ Amount paid on your behalf $ _____

Month and Year of Event precipitating claim: _____

Month and Year of Lawsuit: _____

Insurance Carrier at Time: _____

What is/ was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: _____ Date: _____

Form #3

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____ First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date _____

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: _____

Address _____ City _____ State _____ ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name:_____

School name if different when the above applicant attended:_____

Medical School Address:_____

Street City State ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From_____ To_____ Graduation Date: _____ Degree:_____

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name:_____

AFFIX INSTITUTIONAL SEAL HERE

Title:_____

(If no seal is available, this form must be notarized)

Date:_____

Phone number:_____ Fax: _____

E-mail:_____

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☐ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response ☐ YES ☐ NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

		From Mo/Yr	To Mo/Yr
☐	Academic Probation		
☐	Probation for unprofessional conduct/behavioral		
☐	Probation for other reason		
	Please specify reason:		

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response ☐ YES☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name:_____

First Name:_____

Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number: _____

Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name:_____

Address _____

City _____

State_____

ZIP Code_____

Postgraduate Training Verification - Page 2 of 3

(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name:_____

Institution Address:_____

Street_____

City_____

State_____

ZIP Code_____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year:_____

Internship Residency Fellowship Research Chief Resident Other _____

From Date: _____/_____/_____ To Date: _____/_____/_____

Successfully Completed?: Yes No In Progress

(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	Yes ☐	No ☐
Was this individual ever placed on probation?	Yes ☐	No ☐
Was this individual ever disciplined or placed under investigation?	Yes ☐	No ☐
Were any negative reports ever filed by instructors?	Yes ☐	No ☐
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes ☐	No ☐

Please explain any “Yes” response from above (attach additional pages if necessary):_____

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name: _____

Title:_____

Date:_____

Phone number:_____

Fax: _____

E-mail:_____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name:_____

First Name:_____ Middle Name: _____

Name if different when diploma awarded:_____

Social Security Number:_____

Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name:_____

Address_____

City_____

State_____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name:_____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From_____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE Title: _____

Date:_____

Phone number: _____

Addendum 1
[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☐No
2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☐No
3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐Yes ☐No
4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☐No
5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☐No
6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
   ☐Yes ☐No
7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☐No
8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☐No
9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐Yes ☐No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
    ☐Yes ☐No
11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
    ☐Yes ☐No
12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
    ☐Yes ☐No
13. Are any criminal charges presently pending against you in any of those courts?
    ☐Yes ☐No
14. To your knowledge, are you the subject of an investigation for a criminal act?
    ☐Yes ☐No
15. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court? **(If yes, complete Form # 2 Malpractice Liability Claims Information)**
    ☐Yes ☐No

Have you ever applied for or been issued a Kentucky medical license? ☐Yes ☐No If yes, # _____

Specialty: _____ American Specialty Board Certification: _____

Specify your type of practice: (Please check one box. If more than one box is checked, we will take the first one indicated.)

☐Hospital Base	☐Occupational Medicine	☐Instructor	☐Military
☐Admin. Medicine	☐Research	☐Resident/Fellow	☐Emergency Medicine
☐Private Practice	☐Inactive/Semi-Retired	☐Locum Tenens	☐Teleradiology

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant signed in presence of Notary) **(Date)**

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this ___day of _____

(Month, Year)

_____

(Signature of Notary)

My commission expires: _____

Seal of Notary

"Only the applicant and person authorized by applicant may call regarding the credentialing of your application or be given information during the credentialing process."
Specify name of authorized person:_____

Addendum 2
[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant signed in presence of Notary) **(Date)**

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this ____day of _____
(Month, Year)

_____

Seal of Notary **(Signature of Notary)**

My commission expires:_____

Addendum 3

Temporary Permit Form

KRS 311.575 provides that Temporary permits may be issued **at the discretion of the Executive Director**, provided the applicant for a full license has a **completed application with all supporting documents** on file with the Board, meets all statutory requirements for licensure, and needs to begin working in Kentucky before the next regularly scheduled meeting of the Board. ***You must request the Temporary Permit by completing this form; it is not automatically issued.***

Temporary Permits will not be issued to an applicant who has a prior history of disciplinary action taken by a licensing jurisdiction or hospital, a criminal record, a history of substance/chemical abuse or any negative or derogatory information. This also includes any malpractice cases in the last ten years in which you paid a settlement of $100,000 or more.

The Temporary Permit will not be issued until all administrative screening processes are complete including the FCVS Profile. Do Not make any commitments prematurely. The Board recommends that you do not make any commitments to accept a position in Kentucky until you have a Temporary Permit *in hand*.

You may request a Temporary Permit by completing this form and returning it directly to the Board:

Name: _____, M.D./D.O.
(please print)

Practice Location in Kentucky: _____

_____

Date Temporary Permit Requested: _____

Address Temporary Permit should be mailed: _____

_____

Please Note: You will not be issued a Temporary Permit to practice in Kentucky without a specific Kentucky practice address listed on this form.

Addendum 4

Physicians Name _____M.D. / D.O.

List all hospitals, clinics, etc., other than training where you have practiced medicine within the last five (5) years and send Addendum 4A to each. *(This should also include moonlighting, administrative, and all locum tenens assignments.)*

Dates **(From – To)**	Hospital/Clinic/Office Name	Complete Address	**Indicate Locum Tenens, Moonlighting or Type of Privileges**

Addendum 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility:_____

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician?_____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action._____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
   _____
5. Was the above physician terminated from employment? _____ If yes, please explain in detail.

   Derogatory Information, if any:_____

   Comments, if any:_____

Signature, Date, Title _____

Printed Name _____

Facility _____

Affix Seal Here

Address _____

(If no seal, so indicate)

_____

Phone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source ***directly*** to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave your community?	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

Addendum 5
Page (2) of (2)

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave community	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Addendum 6

Kentucky HIV/AIDS Education
Affidavit of Reasonable Cause

I, _____, request that the Board (KBML) defer my
(Name)

HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: _____

_____

_____

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is **not renewable.** I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: _____ Date: _____

Printed Name: _____

Social Security Number: _____

→ This form must be sent to the Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records. Either this affidavit or the completed course must be in the Boards office in order to meet the Board Deadlines. **A list of approved courses may be obtained from the following website: http://chfs.ky.gov/dph/training or by calling (502) 564-4990.**

Mail this form to the following address:

Medical Licensure Coordinator
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

Addendum 6

Kentucky Board of Medical Licensure
HIV/AIDS Education Certificate Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administers this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for medical licensure must comply with the two (2) hour AIDS education requirement.

Prior to receiving a Kentucky medical license, each applicant for licensure must submit to the Kentucky Board of Medical Licensure one of the following:

- A copy of a certificate of completion of an approved course. The AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by the Cabinet for Health Services, and the CHS approval number must appear on the certificate. **Certificates without a CHS approval number will not be accepted.**

- An "Affidavit of Reasonable Cause" form if the requirement is not met prior to temporary licensure. If the AIDS course is not completed by the time a temporary license is to be issued, the applicant must complete an "Affidavit of Reasonable Cause" form to verify that the requirement will be met within the next six (6) months. This affidavit shall be valid for no more than six (6) months and is not renewable. Eligible applicants will be issued a Temporary Permit only for this six (6) month period. The full license to practice medicine in Kentucky will not be issued until this requirement is met.

- If an applicant has graduated from a medical/osteopathic school, whose AIDS education is approved by CHS, within five (5) years and has been in a residency program throughout the interim, the applicant shall be deemed to have met this requirement. **Contact the AIDS Education Program at CHS to see if your medical school curriculum has been approved**. (See below)

If you have any questions regarding applicable courses, approval of courses, or if you need to obtain a listing of approved courses, please contact:

http://chfs.ky.gov/dph/training

AIDS Education Program
Cabinet for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-4990

CME Form

Name_____
(Please Print or Type)

Record of Category I Continuing Medical Education Credits(Last 3 years)

DO NOT PROVIDE DOCUMENTATION

Dates:	**Name of Activity/Course**	**# of Credit Hours**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I attest that the above is valid.

_____ _____

Signature **Date**

Addendum 8

Kentucky Board of Medical Licensure
Criminal Background Requirements

KRS 311.565

This notice should be provided to all applicants applying for a full-unrestricted Medical/Osteopathic License in the Commonwealth of Kentucky by endorsement.

All persons applying for a Kentucky Medical License on and after August 15, 2003 shall submit proof of a FBI Criminal Background Check to the Board as a part of the application for a license to practice medicine in the Commonwealth. This record must indicate that there have been no felony convictions or pending charges at any time or any misdemeanor convictions or pending charges within the previous five-year period. Some examples of misdemeanors which will be subject to a Board investigation include: DUI, sexual assault, certain theft charges, and drug convictions. In general, speeding and minor traffic violations would not be misdemeanors. Some serious traffic violations could be misdemeanors.

Where can I obtain the necessary FBI forms? To obtain the fingerprint cards, check with your local law enforcement agency (any state), the Kentucky State Police (check www.kentuckystatepolice.org/post.htm for the nearest location), or call the Federal Bureau of Investigation, Criminal Justice Information Services Division at 304-625-3878. You must listen to the Entire recording and request the cards to be sent to you at the very end. You will receive two fingerprint cards in the mail within 3 – 5 days.

Who will take my fingerprints? Most local law enforcement agencies, county sheriff's departments, and some city and county police departments, or any state police post may be able to take your fingerprints. The law enforcement agencies will be taking your fingerprints for a **Personal Review**. Some law enforcement agencies may charge a fee for fingerprinting services. The cost may vary.

What is the cost and where do I send it? Send the completed fingerprint card, a short letter (A sample letter is attached for your review) advising the FBI that the report is desired for personal review, and a certified check or money order, payable to the Treasury of the United States, in the amount of $18 to the address listed below. **If all items are not included, the request will be returned to you by the FBI for correction.**

Federal Bureau of Investigation
Criminal Justice Information Services Section
Attn: Records Request
1000 Custer Hollow Road
Clarksburg, WV 26306

What if my report comes back indicating that the prints are unreadable or indiscernible? If a criminal background report comes back from the FBI indicating that the prints are indiscernible or unreadable, the applicant should have the second set of prints done at the nearest State Police Post and resubmitted to the FBI for processing. If the second report comes back with the same result, then the Board has an affidavit that the applicant can sign before a notary to use for the issuance of a license. All of the **original fingerprint cards and reports** must be submitted along with the affidavit in order for the affidavit to be valid. If the applicant goes to the State Police Post first and that report comes back unacceptable, then he/she must have the prints done at one other location. Thus, no license will be issued to the applicant (using an affidavit) unless there have been at least two FBI reports obtained that indicate a failure to read the prints, one of which resulted in the fingerprints being done by the State Police Post.

Also, we cannot accept a copy of a report that has been done for any other entity or organization. Applicants must have their prints taken and forwarded to the FBI for processing. The original fingerprint card(s) and report(s) must be submitted to our office for processing your application for a medical license.

How long does this process take and how long is the report valid? Approximately **6-8 weeks**, upon submission of the fingerprint card to the FBI. Thus, you should apply for the criminal background report at the time that you submit your application for licensure to the Board. **The report is only valid for one year.**

What should I do if my report is clear? The report will be mailed directly to you. The **original** report(s) and fingerprint card(s) must be submitted for completion of your application for a medical license. Photocopies of the fingerprint card and/or the written report from the FBI are not acceptable.

What happens if I have a conviction or pending charges? You must submit the criminal background report to the Board within five days of receipt of the FBI identification record. The Board will then begin an investigation into the conviction or charges. Just a reminder, you will be asked about any presently pending and/or prior convictions of felonies or misdemeanors on the Board's application for licensure, please be sure to answer these questions in a truthful manner.

If a conviction is noted, how long will the Board's investigation process take? Approximately 60-90 days depending upon how quickly all the documents are returned to the Board and the backlog of cases.

IMPORTANT NOTE: The Board **will not** issue a Medical License to you until we have received the final fingerprint card(s) and background report(s). You may contact the FBI directly at (304) 625-5990.

If you have further questions, please contact the Board's office between 8:00 a.m. and 12:30 p.m., ET, at (502) 429-7150, Ext. 222.

Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Federal Bureau of Investigation
Criminal Justice Information Services Division
1000 Custer Hollow Road
Clarksburg, WV 26306

RE: CRIMINAL BACKGROUND CHECK

I am requesting this background check and report for a personal review. Enclosed is the required, completed fingerprint card, along with the $18 processing fee. (Certified check or money order, payable to: Treasury of the United States).

PLEASE RETURN THE REPORT TO ME AT THE FOLLOWING ADDRESS:

Printed or Typed: _____
Full Legal Name

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Date